JUNE 2002

FRONTLINES

LINKING ALCOHOL SERVICES RESEARCH AND PRACTICE

Editor's Note

As people age, the ways in which they interact with alcohol change. It is estimated that at least 10 percent of older adults drink alcohol above recommended limits, a proportion that may well increase with the aging of the Baby Boomer generation. This issue of *FrontLines* explores challenges specific to alcohol misuse among older adults and reports on how research is addressing these challenges.

In the Invited Commentary, Frederic Blow of the University of Michigan and the Department of Veterans Affairs describes the epidemiology of alcohol abuse in older adults, as well as trends and recent screening and treatment approaches.

Michael Fleming of the University of Wisconsin shares results from Project GOAL, which tested the efficacy of brief physician advice in older problem drinkers.

Derek Satre of the University of California at San Francisco and Kaiser Permanente describes special considerations in treating this population.

Penny Brennan and Rudolf Moos of the VA and Stanford University report on their study of outpatient mental health treatment for older alcohol-abusing VA patients.

From Brandeis University, Mark Sciegaj and John Capitman describe their investigation on the extent of alcohol problems among elder public housing rsidents.

Finally, Sujaya Parathasarathy of Kaiser Permanente explains the concept of cost-offsets from alcohol and drug abuse treatment and how that concept plays out among elderly patients.

We hope that you find this issue useful and informative.

COMMENTARY

Alcohol Use and Misuse in Older Adults: Building Knowledge and Improving Treatment Through Research

By Frederic C. Blow, Ph.D., University of Michigan Department of Psychiatry and Department of Veterans Affairs National Serious Mental Illness Treatment Research and Evaluation Center

Aging changes the context for alcohol-related problems in ways that are still not fully understood. Alcohol affects older adults somewhat differently than younger adults, with potentially serious consequences. In addition, as people age, many factors related to their physical and mental health often change, with possible ramifications for alcohol use. For these and other reasons, people 65 and older face unique challenges around issues related to alcohol, comorbid mental and physical health conditions, and the contraindicated use of alcohol with specific medications.

Better understanding of the epidemiology of alcohol use and misuse in later life is needed urgently. Community surveys estimate that 1 percent to 15 percent of older adults have alcohol problems; prevalence estimates of alcohol misuse among older women range from less than 1 percent to 8 percent. The wide variation in these estimates stems from differences in definitions of risk drinking or alcohol abuse or dependence, as well as differences in the methodology used in obtaining the samples.

Generally, rates of alcohol abuse and dependence appear to decline with increasing age, although this trend is likely to change with the aging of the Baby Boom generation, whose members have had different exposure to alcohol and hold different attitudes toward alcohol use than the current generation of older adults. Strong evidence indicates that up to a third of older problem drinkers started having problems in late adulthood — highlighting the need for prevention programming for this vulnerable population.

Older adults have specific vulnerabilities that can increase their risk for negative consequences from alcohol use and misuse. Because they tend to have more chronic diseases,

continued on page 2

A PUBLICATION OF THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
IN CONJUNCTION WITH THE ACADEMY FOR HEALTH SERVICES RESEARCH AND HEALTH POLICY

they tend also to use more medications than younger people. For some patients, any alcohol use can be problematic when coupled with the use of certain over-the-counter or prescription medications, especially psychoactive medications.

Biological changes may make older adults more susceptible to adverse effects from increased alcohol consumption as well. Lean body mass versus total volume of fat declines with age, and the resulting changes in proportion increase the distribution of alcohol and other mood-altering chemicals in the body. Liver enzymes that metabolize alcohol and certain other drugs are less efficient with age and central nervous system sensitivity increases with age.

Alcohol Linked with Multiple Health Problems

Many signs and symptoms of alcohol problems in later life can be related to other medical and mental health problems, but it is important to rule alcohol in or out of any diagnosis. Physical health changes are often the first changes noted. A number of adverse health effects can be associated with heavier alcohol use, including a greater risk for harmful drug interactions, injury, and mental and physical health comorbidities, such as depression, memory problems, liver disease, cardiovascular disease, cognitive changes, and sleep disorders.

There are effective ways to identify and treat older adults with alcohol problems. The Center for Substance Abuse Treatment (CSAT) has produced a Treatment Improvement Protocol (TIP), *Substance Abuse Among Older Adults* (TIP No. 26), that serves as a comprehensive reference that provides practical advice for clinicians who work with older adults.

CSAT recommends screening all adults 60 and older for alcohol and prescription drug use or abuse. Re-screening should take place yearly, whenever potentially related physical or mental health symptoms emerge, or when the patient undergoes any major life changes or transitions. The goals of screening are to identify at-risk drinkers, problem drinkers, or persons with alcohol dependence; and determine the need for further assessment. Two instruments that have been used successfully with older adults are the Short Michigan Alcoholism Screening Test - Geriatric Version (SMAST-G), developed at the University of Michigan, and the Health Screening Survey (HSS), developed at the University of Wisconsin.

For some patients, any alcohol use can be problematic when coupled with the use of certain over-the-counter or prescription medications.

Brief interventions have been shown to be effective in treating older adults with alcohol problems. Another CSAT TIP (No. 34), *Brief Interventions and Brief Therapies for Substance Abuse*, defines brief alcohol interventions as time-limited counseling strategies targeting a specific alcohol-related behavior. Drinking goals in brief interventions should be flexible, allowing the patient, with guidance from the clinician, to have choice as well as responsibility.

To date, two major brief alcohol intervention trials with older adults have been completed. Researchers at the University of Wisconsin and at the University of Michigan used brief interventions in randomized clinical trials in primary care settings to reduce hazardous drinking with older adults. These studies have shown that older adults can be engaged in brief intervention protocols, with a reduction in drinking among at-risk drinkers receiving the interventions compared to those in the control groups.

More Targeted Research Is Needed

Few studies address the treatment outcomes and unique needs of older adults who meet criteria for alcohol abuse and dependence. Because traditional residential alcoholism treatment programs provide services to very few older adults, sample sizes for treatment outcome studies have often been inadequate. Even this limited research suggests that elderly individuals are more likely than younger adults to engage in and complete treatment. Limited outcomes studies indicate that elderly individuals in alcoholism treatment have outcomes comparable to or better than those of younger adults.

More research is needed on the treatment needs unique to older adults, including the pacing, content, and format of specialized care. The development of elder-specific alcoholism treatment programs in recent years may facilitate studies of this special population's needs.

Aging of Baby Boomers Has Implications

Alcohol use and misuse can have serious consequences for older adults, who have special vulnerabilities that need to be addressed. This is an issue that will gain in significance as the Baby Boomer generation ages.

More research is needed to develop effective prevention programs for this population; interventions and treatments specific to older adults; combined intervention approaches for alcohol and prescription drug misuse; screening and brief intervention protocols for special subpopulations (such as racial and ethnic minorities and homebound adults); and optimal service delivery systems targeted for the growing population of elderly.

Although we've advanced our understanding of the effectiveness of alcohol screening, brief interventions, and specialized treatments for older adults, we still must determine how to incorporate these approaches into a broad spectrum of health care settings and how best to target specific interventions and treatments to a vulnerable, growing, and under-recognized population of older adults who are consuming high levels of alcohol and medications.

To access CSAT's Treatment Improvement Protocols, visit www.samhsa.gov.

Screening and Brief Intervention To Identify and Treat Alcohol Use Disorders in Older Adults

By Michael Fleming, M.D., M.P.H., University of Wisconsin, Madison

At least 10 percent of older adults use alcohol above recommended limits. At-risk older adults are those who drink more than one to two drinks per day, those who drink more than three to four drinks per occasion, and those who drink in high-risk situations such as driving a motor vehicle, before surgery, or while on medication that interacts with alcohol.

Alcohol use is implicated in many health problems among older adults, ranging from falls and injuries to depression, anxiety, confusion, and cognitive loss to hypertension and heart disease to certain cancers and liver failure. In addition, alcohol affects treatment for other health problems and interacts with medications, frequently in clinically significant ways.

Clearly, there is a great need to identify and treat alcohol use problems in this population. Fortunately, several alcohol screening tests are available that are sensitive and specific for older adults.

Screening questions that work well in general primary care samples of older adults include questions on quantity and frequency of alcohol consumption, binge drinking, and the four questions from the CAGE screening questionnaire. These questions can be administered by direct interview as part of routine clinical care, by self-administered questionnaire, or by computer. Screening questionnaires developed specifically for pencil and paper or computer administration include the Alcohol Use Disorder Identification Test (AUDIT), PRIME-MD, and the geriatric version of the MAST. Appropriate interview techniques that use a direct and nonjudgmental approach, collaborative reports by family members and medical record review, and laboratory tests can help identify problems, especially in persons who are alcohol-dependent, cognitively impaired, or intoxicated.

A clinician who identifies a patient drinking above recommended limits may want to administer a brief intervention — a time-limited, patient-centered counseling strategy that focuses on changing behavior and increasing medication compliance. Brief interventions have been found to be effective in helping non-dependent older adults reduce their alcohol use. They may also be used in referring alcohol dependent subjects to counselors.

Elements of brief intervention include assessment, direct feedback, contracting, behavioral modification, and follow-up. The classic brief intervention performed by a physician or nurse usually lasted for five to 10 minutes and was repeated one to three times over six to eight weeks. Other trials have utilized therapists, social workers or psychologists as the interventionist, usually in counseling sessions of 30 to 60 minutes for one to six visits. Some trials developed manuals or scripted workbooks. Others studies left it up to the interventionist to decide how to conduct the intervention based on a training program. Only one study was specifically conducted on a sample of older adults.

Project GOAL (Guiding Older Adult Lifestyles) was designed to test the efficacy of brief physician advice in problem drinkers over age 65. Forty-three physicians from 24 community-based primary care practices located in eight Wisconsin counties were recruited and trained. Of the 6,073 patients screened for problem drinking, 105 men and 53 women met inclusion criteria and were randomized into a control or intervention group. Of those, 146 participated in follow-up procedures. The 24-month follow-up indicated a significant reduction in seven-day alcohol use, episodes of binge drinking, and frequency of excessive drinking. This is one of the few brief intervention trials where there were no post-randomization changes in drinking in the control group. No significant changes in health status were demonstrated, and there were too few utilization events during the 24 month follow-up period to estimate differences in health care utilization and costs between groups.

These results demonstrate that older adults with alcohol problems can benefit significantly from brief interventions designed to reduce alcohol use. Clinicians need to take a more active role in preventing, identifying, and treating alcohol-related problems in persons over age 65.

Reference:
Fleming MF, Manwell LB, Barry KL, Adams W, Mundt M, Stauffacher E. "Brief physician advice for older adult problem alcohol drinkers: A randomized controlled trial." Journal of Family Practice, 1999;48(5):378-84.

For a complete list of references, please contact the author at mfleming@dfmp1.fammed.wisc.edu.

Drinking Guidelines for Older Adults

NIAAA and the Center for Substance Abuse Treatment recommend that adults 65 and older consume no more than one standard drink per day or seven standard drinks per week. In addition, older adults should consume no more than two standard drinks on any drinking day.

The recommended limit for older women is slightly less than one standard drink per day. Those with certain medical or psychiatric comorbidities, or who are taking psychoactive medications, should consult with their health care provider before consuming alcoholic beverages.

Special Considerations in Treating Alcohol Problems Among Older Adults

By Derek D. Satre, Ph.D., University of California at San Francisco
Division of Research, Kaiser Permanente Medical Care Program, Oakland, Calif.

Treatment of alcohol problems in older adults has been the subject of increasing research and clinical interest in recent years. Although community prevalence rates of alcohol abuse and dependence among older adults are lower than among younger adults, the negative effects of alcohol misuse among older adults are substantial. Excessive alcohol consumption is associated with numerous physical and psychological problems in older people, including malnutrition, accidental injury, dementia, depression, and suicide.

Most older adults continue to be treated in mixed-age settings, so it is important to be aware of age-associated differences in clinical needs.

Alcohol problems of older adults include a spectrum of disorders that range in severity from long-term dependence, at the most serious end, to individuals considered "at risk" for problems due to heavier-than-recommended alcohol consumption. Screening for these problems is complicated by the fact that many older adults do not meet criteria for dependence or abuse. Older adults may not experience the social, legal, and psychological consequences commonly associated with alcohol abuse, and are therefore underdiagnosed. In addition, consumption levels used in identifying younger adults with alcohol problems may be too high for older adults, who may drink smaller quantities yet be at risk for serious alcohol-related consequences. For example, a consensus panel convened by the Substance Abuse Mental Health Services Administration recommended no more than one drink per day for older adults.

Age-Specific Physical and Mental Health Issues

Most older adults continue to be treated in mixed-age settings, so it is important to be aware of age-associated differences in clinical needs. Patient characteristics to consider in treatment planning include substance abuse diagnosis and physical and psychiatric comorbidity.

Overall, older adults in treatment are most likely to have problems with alcohol, and are less likely to present with illicit drug abuse or dependence. Older patients frequently have more problems with physical health than younger patients, suggesting greater need for coordination with medical services. In contrast, younger patients have more social, family, and legal problems.

Psychiatric comorbidity may differ by age. Older adults in treatment are less likely to present with personality disorders, post-traumatic stress disorder, or schizophrenia, but are more likely to have dementia. Depression and anxiety are common among both older and younger patients. Identification of these co-occurring disorders is essential to treatment success.

Adapting Treatment

To best meet the needs of older adults, modifications to intervention content, counseling method, and treatment setting are recommended. Due to the range of disorder severity, interventions must also take into account specific treatment needs. For at-risk drinkers, motivational interviewing and brief intervention strategies have been suggested as initial approaches that are minimally invasive. Older adults should receive feedback regarding the physical, psychological, and social consequences of excessive alcohol use. Clinicians should emphasize reasons for patients to cut down or quit drinking, such as avoiding physical health consequences and cognitive problems and maintaining independence and financial security. Because older people may be particularly sensitive to shame and guilt around drinking, it is best to avoid labels such as "alcoholic" or "addict," as well as confrontational tactics.

Group counseling is a component of many inpatient and outpatient programs. In these sessions, it may be useful to discuss stresses associated with aging such as widowhood, physical disability, chronic illness, retirement and social isolation. Group leaders should be prepared to discuss concerns that may not appear directly related to drinking behavior. Attention to aging issues may be particularly important for those patients identified as late-onset drinkers, whose alcohol problems may be exacerbated by aging-related stresses.

In addition, counselors need to take into consideration cognitive and physical health problems that older adults may have and adapt their counseling methods accordingly — for example, speaking louder or more slowly, using simpler language, slowing the pace of structured intervention components, and repeating material more frequently. Such adaptations may be important to increase treatment effectiveness. In a group setting, it may be necessary for group leaders to be more active and to provide more structure than they might with younger adults.

Treatment Settings

Comorbid physical illness and disability need to be accommodated, to the extent that these problems decrease mobility and access to care. Treatment centers are ideally located somewhere convenient to older adults who may not drive and may

continued on page 8

Older Patients with Alcohol and Drug Use Disorders Respond Well to Outpatient Mental Health Treatment, But Access to Care Is Limited

By Penny L. Brennan, Ph.D., and Rudolf H. Moos, Ph.D., Center for Health Care Evaluation, Department of Veterans Affairs and Stanford University

A growing body of research focuses on the utilization and effectiveness of outpatient mental health treatment among older people who have alcohol and drug use disorders. Specifically, recent research has addressed:

- the extent to which older individuals with alcohol and drug use disorders obtain specialized outpatient mental health services;
- whether these patients get the same amount of outpatient mental health care as do younger patients with alcohol and drug use disorders; and
- treatment outcomes of older patients with alcohol and drug use disorders.

Relatively few older people with alcohol and drug use disorders obtain specialized outpatient mental health care. For example, we found that only 12 percent to 17 percent of elderly Medicare inpatients with diagnosed substance use disorders received outpatient mental health care in each of four years after hospital discharge. Cumulatively over four years, 29 percent of patients obtained outpatient mental health care. About 60 percent of patients who obtained outpatient mental health care made 10 or fewer visits for such care over the entire four-year interval.

On a more promising note, nationwide Department of Veterans Affairs (VA) patient treatment records show that 47 percent of older patients with alcohol and drug use disorders obtained outpatient mental health treatment in the first year following hospital discharge, and 62 percent of patients obtained such care in the four-year interval after discharge.

The higher rate of outpatient mental health care among older VA substance abuse patients suggests that two unique characteristics of VA health care may facilitate prompt and continued access to outpatient mental health care: single-site treatment delivery and better integration of inpatient and outpatient treatment services. Diagnostic complexity — more chronic use problems or the presence of a concomitant psychiatric disorder — also facilitates access to and use of outpatient mental health care for older patients.

Advanced age, physical health problems, and travel distance make it more difficult for older abuse patients to obtain outpatient mental health services. Older men and older African-Americans are less likely to obtain these services than are older women and whites. Older patients may also be unable to surmount financial barriers, such as the Medicare 50 percent copayment for outpatient mental health services.

Removing Barriers to Outpatient Treatment

Recent research highlights the importance of removing these barriers, because when older patients receive outpatient mental health care, they have favorable treatment prognoses. We recently compared the baseline substance use and functioning of a nationwide sample of almost 3,600 older substance abuse patients to a demographically and diagnostically matched sample of younger patients. Older patients tended to have more medical problems and somewhat lower motivation for treatment than did younger patients. However, they also had fewer substance-related psychiatric, family, and legal problems.

Once in treatment, older patients obtained about the same amount of care as did younger patients. After relevant demographic, diagnostic, and treatment factors were controlled, older and younger patients made a comparable number of substance abuse and psychiatric clinic visits and had similar duration and intensity of care.

Older adults who have substance use disorders also have positive treatment outcomes and do as well or better in treatment than do younger patients with substance use disorders. Older patients with substance use disorders respond well to outpatient treatment programs focusing on their special needs. One study showed that, after obtaining combined inpatient and outpatient substance abuse treatment services, older patients showed better outcomes than did younger patients, as demonstrated by alcohol use at six-month follow-up. When we compared older and younger substance abuse patients on risk-adjusted 12-month follow-up outcomes, older patients had better outcomes in substance use, psychiatric symptoms, family problems, and legal difficulties.

In summary, current research shows that relatively few older adults with substance use disorders receive the outpatient mental health care they need. Health, financial, travel, and service-delivery factors are among the barriers that stand in their way. It is important to further identify and remove such barriers, because older people with alcohol and drug use disorders who do obtain outpatient mental health care participate in treatment at levels comparable to those of younger patients. They are also as likely to experience remission and improved psychosocial functioning.

For references, contact Dr. Brennan at (650) 493-5000, extension 23440, or by email at penny.brennan@med.va.gov.

Measuring Alcohol Use and Health and Housing Crises Among Older People in Public Housing

By Mark Sciegaj, Ph.D., and John A. Capitman, Ph.D.
Brandeis University

Despite increasing attention to the negative consequences of both lifetime alcohol abuse and current alcohol use among elderly people, there is little consensus regarding the prevalence and patterning of problem drinking in old age. However, previous studies have reported that elders residing in public housing have elevated rates of alcohol abuse and related mortality, morbidity, and other problems, including disruptive behavior and self-neglect. Nearly 40 percent of the approximately 3 million public housing residents in the United States are 62 or older.

To explore the extent of alcohol use and related alcohol problems, we surveyed 144 elder residents in one Boston Housing Authority property from September 1999 to February 2000, using the Alcohol Use Disorder Identification Test (AUDIT) to identify possible alcohol use problems. AUDIT consists of 10 Likert scale questions with a total response range between zero (a non-drinker) to 40.

Elders residing in public housing have elevated rates of alcohol abuse and related mortality, morbidity, and other problems.

Among the residents we initially surveyed, 61 reported at least some current drinking. We interviewed 44 of those current-drinking residents using the alcohol module of the Structural Clinical Interview for DSM-IV (SCID) between May 2000 and September 2000. In addition, we tracked the entire sample of 144 residents (using building management and security records) for health and housing crises from September 1999 through September 2001.

Our study examined two primary hypotheses: (1) elders identified as problem drinkers would have worse health status, less adequate social supports, and less access to health care than other elder public housing residents, and (2) elders identified as problem drinkers would be at greater risk for emergency medical service use and other health and housing crises. In addition to exploring these theories, the study attempted a preliminary test of the sensitivity and specificity of the AUDIT against the alcohol abuse or dependence diagnoses from the SCID.

Health Problems Cited

Descriptively, among the 144 elders in this study, the majority was male (55 percent) and living alone (73 percent). The average age was 67. The majority of respondents were African American (57 percent), with Latinos composing the next-largest racial or ethnic group (27 percent).

When questioned about their health and functional status, 73 percent of the study group said that they were somewhat limited in their ability to perform daily activities, 29 percent reported receiving assistance for these activities, and 48 percent rated their health as "fair" or "poor." In addition, 46 percent said they smoked, and 30 percent smoked five or more cigarettes a day. About 49 percent said that they had tried to lose weight during the last year. On questions concerning health care service use and access, 94 percent reported seeing a doctor at least once during the previous three months, 25 percent reported being taken to the emergency room, and 42 percent reported not being able to access needed health care.

Using AUDIT scores to measure problem drinking patterns in the full study sample, the study found that 8 percent could have problem drinking patterns. However, 13 percent of respondents indicated binge drinking (drinking more than six drinks in one sitting) at least monthly during the past year. Although bivariate analyses found no association between AUDIT-classified problem drinking and health and housing problems, respondents who acknowledged any current drinking were more likely to experience those negative outcomes, receive assistance with personal care, and smoke. There were no significant racial or ethnic differences with respect to problem drinking based on AUDIT scores.

Results from the 44 personal interviews using the SCID identified respondents who either had a drinking problem or developed a tolerance for alcohol. In that subgroup, 25 had developed a tolerance for alcohol and an additional seven were identified as problem drinkers. These results reflect a much higher rate of problem drinking than indicated by AUDIT self-reports on this same group.

These findings suggest that AUDIT may not be an adequately sensitive measure of problem drinking in this population, compared with the SCID. They also appear to be consistent with prior research indicating that even low levels of current drinking may have negative health and housing consequences for older people. However, the size of the sample for which SCID data are available prevents a full assessment of these alternative interpretations. While analyses of the data collected in this study continue and multivariate models testing the study hypotheses need to be assessed, the bivariate findings suggest that further study with elders in public housing is merited.

Understanding Cost-Offset for Treating Alcohol and Drug Abuse in Older People

By Sujaya Parathasarathy, Ph.D.
Drug and Alcohol Research Team, Kaiser Permanente Division of Research, Oakland, Calif.

Research demonstrates that people with alcohol and drug problems consume health care services at higher rates than those without, but that only a small fraction of costs for those services are directly attributable to alcohol and drug abuse treatment. Service utilization, especially inpatient and emergency department use, tends to peak in the period immediately preceding treatment entry and decline in the post-treatment period. This potential for reduced medical service utilization and cost following treatment is known as the "cost-offset" effect.

Cost-offset has been promoted as a way for alcohol and drug abuse treatment to pay for itself by generating reductions in health care utilization in other areas. Research conducted in the 1980s and early 1990s demonstrated a distinct pattern of reduced medical use following treatment. Estimates of reduction in costs vary between $0.40 and $1.10 for every dollar spent on treatment.

Different Levels of Cost-Offset Effects

One study found that returns on investment in alcohol treatment were realized in about 30 months post-treatment. Another study suggests that offset effects differ by abstinence status following treatment, with treatment successes producing greater reductions in the use of inpatient days. Cost-offset effects have also been observed among family members of alcoholics who may or may not have alcohol problems.

Few studies have examined offset by the individual components of cost (medical, psychiatric, or treatment) and by demographic characteristics such as gender and age. One study concluded that cost offsets were less likely among older patients. Recently, my colleagues and I found that for a sample of outpatients entering alcohol and drug abuse treatment, utilization and costs were significantly reduced among individuals ages 40 to 49 at 18 months post-treatment, compared to a demographically matched sample of individuals without substance use. Other research suggests that cost-offset effects are determined by a complex interplay among age, gender, and type of utilization (e.g. medical vs. psychiatric). Women ages 40 to 49 were likely to have equal reductions in medical and psychiatric costs, but the greatest reductions were observed in medical costs of women over age 50.

Most studies to date have focused on young and middle-aged adults. It is estimated that one-third of older alcoholic persons develop a problem with alcohol in later life, while the other two-thirds grow older with the medical and psychosocial consequences of early-onset alcoholism. Based on demographic projections and substance abuse trends indicating that Baby Boomers have higher life expectancy and heavier drinking habits than the current cohort of older adults, it is expected that substance use problems among those 65 and older will rise as boomers age.

Prevalence Among Elderly Underestimated

Studies using currently available diagnostic criteria for alcohol-related problems are likely to significantly underestimate the prevalence of alcohol abuse among older persons because those criteria were developed and validated on younger samples. Changes in physiology and pharmacokinetics have different implications for older substance using patients. Among this age group, misuse of prescription drugs use may be more of an issue than illicit drugs. Lower tolerance to alcohol with age may result in alcohol problems that in a younger population might be less severe. The common definitions of alcohol abuse and dependence may not apply as readily to older persons who have retired or have few social contacts, and who may metabolize alcohol differently than younger people. These factors all have important implications for costs and cost-offsets.

The potential for reduced medical service utilization and costs following treatment is known as the "cost-offset" effect.

Treatment prognosis is generally better for older patients than younger patients. However, because older people tend to have more chronic medical problems, health care costs and services increase with age and may not decrease with treatment for alcohol and drug problems. The net effect of these opposing forces on cost-offset among older adults with alcohol and drug problems has not been studied.

Recent technological and methodological developments have spurred an increase in the number of studies that address cost issues in alcohol and drug abuse services research. The time is ripe to launch new studies that specifically focus on the older adult populations.

For complete references, please contact the author at sxp@dor.kaiser.org.

Satre
continued from page 4

have disabilities that limit physical mobility. For outpatient treatment, such a location may be a senior center. Senior centers are advantageous because clients are already familiar and comfortable with the surroundings. Using a familiar multi-service setting may reduce potential stigma associated with seeking treatment for an alcohol problem.

These adaptations may be more easily accomplished if older patients are treated in age-specific as opposed to mixed-age settings. The advantages of one over the other have been debated, and there is some evidence that age-specific treatments are more effective. Even in mixed-age settings, older patients appear to respond to treatment at least as well as younger adults. However, more research on these questions is needed.

In summary, research and clinical experience suggest that older adults with alcohol and drug abuse problems have distinct clinical features and treatment requirements that clinicians should be aware of. Further study of treatment needs and outcomes of older adults is needed to refine treatment adaptations and determine their efficacy in treating drinking problems in this population.

For references, contact the author at DerekS@lppi.uscf.edu.

NIAAA Seeks Research Applications

NIAAA continues to invite applications for research funds across a broad range of questions in health services research on the delivery of treatment and prevention services for alcohol-related problems, including alcohol dependence and alcohol abuse. NIAAA is particularly interested in supporting research that investigates several specific types of questions: studies of cost analysis, cost effectiveness, cost benefit, and cost-offset of alcohol services; studies of the adoption in clinical practice of scientific advances in the treatment of alcohol dependence and abuse; and secondary analyses of currently existing health services data sets. Detailed information can be obtained from the NIAAA web site, www.niaaa.nih.gov, or from the specific program announcements:

- http://grants.nih.gov/grants/guide/pa-files/PA-01-142.html;
- http://grants.nih.gov/grants/guide/pa-files/PA-01-137.html;
- http://grants.nih.gov/grants/guide/pa-files/PA-01-058.html;
- http://grants.nih.gov/grants/guide/pa-files/PA-00-100.html.

FRONTLINES
LINKING ALCOHOL SERVICES RESEARCH AND PRACTICE

FrontLines is published twice a year by the Academy for Health Services Research and Health Policy. For further information contact AHSRHP at 202/292-6700.